Alternative Means Screening (AMS) Instruction Sheet

During April 1, 2013 thru May 31, 2013, the State of Nebraska provides the opportunity for employees enrolled in any health plan to attend a free, confidential on-site biometric screening. The biometric screening allows the opportunity to learn about your health risks and qualify for the Wellness Health Plan.

Those who are unable to attend the on-site biometric screenings can take advantage of the "Alternative Means Screening Process" which provides another option to complete your biometric screening to qualify for the Wellness Health Plan. **Print and provide the AMS form to your health care provider to complete. NOTE: Only the AMS form will be accepted - do not submit any other forms! Participants can submit your biometric results from a Doctor visit scheduled after January 1, 2013 by submitting a completed "Alternative Means Screening Form and Release" by fax or mail between April 1, 2013 and April 30, 2013 midnight.**

NOTE: Forms that are faxed or postmarked after April 30, 2013 midnight WILL NOT BE ACCEPTED.

Please complete the following steps:

1. Call your health care provider for an appointment after **January 1, 2013** and make sure that you have the following standard biometrics measured:

   - **Height**
   - **Weight**
   - **Blood Pressure**
   - **Total Cholesterol**
   - **LDL**
   - **HDL**
   - **Triglycerides**
   - **Glucose**

2. After your biometrics have been measured, ask your health care provider to complete and sign Section 2, then return the "Alternative Means Screening Form and Release" to you for you to submit to HealthFitness.

   NOTE: DO NOT depend on your health care provider to submit the form for you. Participants must be responsible for submitting the form completely and properly. Tip: Save your fax confirmation receipt.

3. Review your form carefully before submitting, as HealthFitness will only process those forms that have been completed in its entirety. The form will be considered incomplete if any item is left blank or your health care provider does not sign this form. In addition, you may not be eligible to qualify for the Wellness Health Plan if you do not submit your completed form. **NOTE: Only the AMS form will be accepted - do not submit any other form or lab reports obtained from your appointment.**

4. Submit your completed "Alternative Means Screening Authorization Form and Release" by fax or mail between April 1, 2013 and April 30, 2013 to HealthFitness Corporation at:

   Fax Number: 1-866-698-9924
   (Save your fax confirmation receipt.)

   OR

   Health Fitness Corporation
   18325 Waterview Parkway, Suite B200
   Dallas, TX 75252
   (Please write "State of Nebraska" in lower left corner of the envelope.)

5. These professionally collected results will be uploaded into your online Health Assessment within 15 days, which will over-ride any self-report values previously entered. Remember to complete your online Health Assessment during April 1 thru May 31, 2013.

   If you have any questions on the Alternative Screening option, please call HealthFitness Customer Service at 866-956-4285. Your personally identifiable data will remain confidential and will not be shared with the State of Nebraska, in accordance with HIPAA federal regulations.

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Alternative Means Screening (AMS) Form and Release

To participate in the State of Nebraska Alternative Means Screening option, this form must be completed in its entirety and clearly. The form will be considered incomplete if any item is left blank or your health care provider does not sign this form. If this form is incomplete, you will not be eligible to qualify for the Wellness Health Plan. **Participants can submit your biometric results from a Doctor visit scheduled after January 1, 2013 by submitting a completed "Alternative Means Screening Form and Release" by fax or mail between April 1, 2013 and April 30, 2013 midnight.**

SECTION 1: PARTICIPANT MUST COMPLETE THIS SECTION			
Employee/Spouse ID (this is your 8 digit "User Name" log-in number):		**Full Name**:	
Date of Birth:		**Gender**:	☐ Male ☐ Female
Preferred Telephone Number:		**Email Address:** (to receive receipt confirmation)	

BY SUBMITTING THIS FORM TO HEALTHFITNESS (WHETHER OR NOT SIGNED BY YOU), YOU HEREBY CONSENT TO THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION AS DESCRIBED BELOW.

Use and Disclosure of Your Information:

HealthFitness treats personally identifiable health information as confidential. The information you provide to us on this form will be used to:

- Generate a personalized health report for you.
- Generate a summary report so that your employer can understand the overall health strengths and concerns of the group. Your individual responses cannot be identified in the summary report.
- Inform you about materials, programs and services that might be useful to you.

The information you provide may be disclosed to the following individuals or groups as appropriate (as determined at HealthFitness' sole discretion):

- Authorized HealthFitness employees;
- Authorized individuals working for your employer or other third parties to the extent reasonably necessary for us to operate employer-sponsored programs in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Assigned contractors, their agents and successors whom we use to support our business in connection with any program sponsored by your employer in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Vendors, contractors and other third parties authorized to provide services and/or programs for your employer's health management plan, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Those involved with the sale, assignment or transfer of business to which the information you give is related, provided they sign appropriate confidentiality agreements that maintain the confidentiality of your information;
- Those with whom we are required to share your information by applicable law, court orders or government regulations; or
- Health care personnel for treatment purposes including, for example, emergency assistance personnel.

MEDICAL FACILITY INFORMATION:

I hereby authorize the medical facility listed below to release biometric assessment data to HealthFitness.

Facility Name:		Telephone Number:	

Participant Signature:_____ **Date**:_____

SECTION 2: HEALTH CARE PROVIDER MUST COMPLETE AND SIGN THE INFORMATION BELOW

Are you fasting? This means you have NOT had anything to eat or drink other than water or coffee/tea without sugar or cream in the last 9-12 hours. Note: *If you have not fasted you may still participate, however, some of your measurements maybe affected.* ☐ Yes ☐ No

Height in inches:		Weight in pounds:		Waist:		Total Cholesterol:	
HDL:		LDL:		Triglycerides:		Glucose:	
Blood Pressure:	/						

Health Care Provider Name (Please Print):_____

Health Care Provider Signature:_____ Date:_____

stateneb **Fax Number: 1-866-698-9924 (**Save your fax confirmation receipt.)